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ABSTRACT

A summary of child outpatient discharges from a mental health center over a 1-year period is given in terms of four classes of variables: client (age, diagnosis, impairment level), treatment time (length of stay, number of sessions, density of treatment), process (principal therapist by discipline, broken or cancelled scheduled appointments), and discharge (reason and need for further treatment). (CL)

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Child Outpatient Discharges, 1975-1976
Description of the Sample

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Before describing the subjects and the variables that were employed in the study, I'd like to briefly describe the setting. The Hahnemann Community Mental Health Center was established in 1967 in association with Hahnemann Medical College and Hospital in Philadelphia. The catchment area served by the center contains a population of about 130,000 people, of whom 57% are black, 6% are Puerto Rican and the rest, white. Children number 72% black, and 8% Peurto Rican. The center is decentralized with over 20 service units scattered throughout the catchment area. Over 5,000 patients pass through the center annually and on any given month, there are about 2,900 active patients.

To give you some idea of the variety of services offered; there are both adult and child inpatient units in separate hospitals, separate partial hospitalization programs for adults, adolescents, and mentally retarded adults and adolescents; a day care center for developmentally-disturbed pre-schoolers; a geriatrics unit, and two addiction units. There are, of course, outpatient

clinics for both children and adults. The focus of our panel today is on our five child outpatient units. These are separate outpatient clinics placed so that all children in the catchment area will be reasonably close to a child outpatient clinic.

The sample for the study consisted of 139 child patients discharged during a 12-month period that began in March 1975 and ended in March 1976. The patients were all first admissions to the center who had not been readmitted by the end of the 12-month period. To be included in the study, the children had to have received at least two or more outpatient treatment sessions on different days.

This study has mainly involved a records search but, as you'll see, at the end of the presentation, we're moving into a field study. I think the whole study illustrates the importance of a good records system for research purposes. You can learn a lot about your operation from looking at a well-designed records system. The big advantage is that you don't have to bother busy clinicians with research questions until you have well-formulated hypotheses from the records research. We have a computerized

central records system at Hahnemann. We get monthly output reports containing patient information, staff information and treatment information. We have one report in particular that we used to gather most of the information for this study. It's called the Discharged Patient Treatment Report. This is a monthly report. It contains the names of all patients discharged from a service unit during that month. Their age, sex and race is listed next to the name. This report also shows what date they were admitted to the unit, their DSM II intake diagnosis, and the degree of impairment (whether it was serious, moderate, etc.), (I'll talk about our impairment code in a minute.). When the patient is discharged, we get additional information:

- date of discharge
- diagnosis at discharge
- impairment level

and the reason for discharge and whether or not the patient needs further treatment

We also get a listing of each outpatient treatment the patient received during the treatment episode - that is every outpatient contact

between admission and discharge. This listing gives the date of treatment, the type of treatment - individual, group, family/couple, etc., and whether the session was held or was broken or cancelled. Broken and cancelled appointments will be mentioned later in this panel, so I'll define them now. They are both types of appointments that aren't held. Broken appointments are when the patient simply doesn't show up without notifying the therapist, and cancelled appointments are when the patient doesn't show but notifies the therapist first. Where the treatment was given (clinic, home, school, etc.) is also on the report, as well as the name of the therapist giving the treatment. This describes the report that was the main data source for the study. With so complete a report, it's not that hard to do a discharge study.

O.K., I'm going to describe the subject sample and the study in terms of four classes of variables. These are client variables, treatment time variables, process variables and discharge variables. Client variables we defined as such things as age, sex, race, diagnosis and impairment level. In terms of sex breakdown, we had

a majority of males - 60% male. This percentage agrees with the results of a previous study we did on child outpatient discharges in 1972. In terms of race, we had 65% black children, 10% Peurto Rican and 25% white. This ethnic breakdown we found in the earlier study, and it also reflects the ethnic composition of children in the catchment area.

Age: The average age of the current sample was 11 with a range of one year to 17 years. In the previous sample, the mean age was 12. Females tended to be older than males in the current study. The female mean was 11.8; the male mean was 10.3.

Diagnosis: Seventy two percent of our sample were diagnosed as Transient Situational Disturbance on admission, with 73% receiving this diagnosis at discharge. Transient Situational Disturbance is, as most of you know, the most common diagnosis for children and adolescents.

Behavioral disorders of childhood and adolescence was the second most frequent diagnostic category at admission and discharge: 8% at admission, 9% at discharge. No child was given a psychotic

diagnosis at admission, and only one child was diagnosed as psychotic on discharge. It's hard to know how many psychotic children were hidden in the transient situational disturbance diagnosis.

The final client variable was impairment level. The impairment scale that we employ at Hahnemann was created by us at Hahnemann, and it's called the Hahnemann Child Impairment Scale. If you refer to handout "A", you can look at it. It consists of six levels of impairment, ranging from not impaired to severely impaired, which defines the child as needing institutional placement. Each level asks the clinician to compare the patient to a normal child of the same age and sex. When we created the scale we focused not only on emotional disturbance, but on socialization, self care, organicity and mental retardation. Each of these areas is mentioned in every impairment level; the higher the impairment level, the more serious the disturbance in the area. The scale allows us to classify children in terms of general functioning in their environment rather than just psychopathology. If you'll

look at handout "B", you'll see the breakdown of patients falling into each of the six categories of impairment at admission and at discharge. At admission, 68% of the patients were seen as mildly or minimally impaired, or not impaired. Only 3% were seen as seriously or severely impaired. At discharge, 73% of the patients were seen as mildly or minimally impaired, or not impaired; and 9% were seen as seriously or severely impaired. The relationship between impairment level at admission and at discharge is going to be discussed in detail later in the panel so I won't say any more.

The second class of variables was treatment time. This included three variables:

1. length of stay
2. number of sessions
3. density of treatment

(1) Length of Stay is the number of days from date of admission to date of last treatment. The mean was 91 days and 58% of the patients fell at, or below this mean of 91 days.

(2) Number of Sessions was the total number of scheduled and unscheduled sessions received by the patient during the length of stay. There was an average of 6.5 sessions per patient.

(3) Density is a fraction arrived at by dividing the number of sessions by the length of stay in days. The average was four sessions per month for the total sample of patients. This average controls for the fact that the children were in treatment for different lengths of time, and had different numbers of sessions.

The third class of variables were process variables. These were variables that in some fashion related to the therapeutic process. There were two of these variables.

The first was Principal Therapist By Discipline. The principal therapist was the therapist who delivered more than 50% of the treatment sessions. We excluded cases where two therapists shared treatment. This left 127 clients for analysis. Therapists were classified by their professional discipline. We had psychiatrists, psychologists, social workers, mental health workers, and students. The original analysis of principal therapist by discipline

included students. Later analyses, which will be described further on in the panel, excluded students. The most frequent therapist discipline for providing therapy was psychologist (34%), followed by social worker (29%), mental health worker (20%) and psychiatrist (11%). Combining the three professional disciplines of psychologist, social worker and psychiatrist, we find that 74% of the sample had their principal treatment by professionals.

The second process variable was the rate of scheduled appointments that were broken and/or cancelled. This rate was arrived at by dividing the number of broken and cancelled appointments by the number of scheduled sessions that were held, plus the number of broken and cancelled appointments. The rate was .30, which means that 30% of all scheduled appointments were broken or cancelled.

The fourth class of variables involved discharge. There were two variables involved: Reason for Discharge, and Needed Further Treatment at Discharge. These are both shown on handout "C".

Of the seven reasons for discharge: "Family Withdrew Patient" was the most frequent reason for discharge (40%), with "Mutual Decision" second (23%). "Patient Withdrew Self" accounted for 12% of all discharges. Taking "Family Withdrew Patient" and "Patient Withdrew Self" together, 52% of the patients left treatment without the therapist's approval. Only 6% of the patients were discharged by the therapist. "Needs Further Treatment" is also on handout "C". As you can see, 75% of the patients were seen as needing further treatment.

This is about all I have to report on. In summary, this was a sample of clients whose treatment was short term, and who were largely treated by professionals rather than non-professionals. Comparing the current sample to the earlier sample, it appears that we are seeing in general the same type of child outpatient now that we did in 1972: 60% male, average age 11 (it was 12 in 1972), and the same ethnic composition.